SERFF Tracking Number: FRCS-126995957 State: Arkansas
Filing Company: Columbian Life Insurance Company State Tracking Number: 47828

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

### Filing at a Glance

Company: Columbian Life Insurance Company

Product Name: Mortgage Term Life SERFF Tr Num: FRCS-126995957 State: Arkansas TOI: L04I Individual Life - Term SERFF Status: Closed-Approved-State Tr Num: 47828

Closed

Sub-TOI: L04I.500 Other Co Tr Num: 5431.7 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Author: Jana Finlay Disposition Date: 01/31/2011
Date Submitted: 01/28/2011 Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

### **General Information**

Project Name: CML-2/61.7 Status of Filing in Domicile: Pending

Project Number: 61.7 Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Submitted on or

about this same date.

Explanation for Combination/Other: Market Type: Individual Submission Type: New Submission Individual Market Type:

Overall Rate Impact: Filing Status Changed: 01/31/2011

State Status Changed: 01/31/2011

Deemer Date: Created By: Jana Finlay

Submitted By: Jana Finlay Corresponding Filing Tracking Number:

Filing Description:

We have been retained by Columbian Life Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$100.00 has been sent by EFT on this same date.

The Company previously filed the applications under SERFF Filing FRCS-126924641/ DOI# 47481 and received approval on 12/10/2010. After the applications were approved, the Company noted that questions needed to be revised so they could apply to all applicants for insurance. As a result, questions have been revised to apply to "any proposed insured." The application form numbers have been revised.

SERFF Tracking Number: FRCS-126995957 State: Arkansas
Filing Company: Columbian Life Insurance Company State Tracking Number: 47828

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Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

The Company also revised the signature line of Proposed Insured (page 3), by deleting "(Parent/Guardian if 15 or under)" for both applications.

The following change was made in the application FORM NO. A432-CL on the bottom of page 3 and the accompanying checkboxes, by deleting "HAS THE TELEPHONE INTERVIEW BEEN COMPLETED?" in the "Report of Licensed Agent" section.

Other minor changes were made as well. Redlined version of the initial and reinstatement applications, with changes noted, are attached under supporting documentation.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

### **Company and Contact**

### **Filing Contact Information**

Jana Finlay, Senior Compliance Specialist jana.finlay@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2741 [Ext]

Suite 201 816-391-2755 [FAX]

Kansas City, MO 64105

### **Filing Company Information**

(This filing was made by a third party - FC01)

Columbian Life Insurance Company CoCode: 76023 State of Domicile: Illinois

4704 Vestal Parkway East Group Code: 535 Company Type:
P.O. BOX 1381 Group Name: State ID Number:

Binghamton, NY 13902-1381 FEIN Number: 16-1321681

(800) 328-2739 ext. 203[Phone]

-----

### **Filing Fees**

Fee Required? Yes
Fee Amount: \$100.00

Retaliatory? No

Fee Explanation: \$50.00 per form x 2 forms = \$100.00

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

SERFF Tracking Number: FRCS-126995957 State: Arkansas

Filing Company: Columbian Life Insurance Company State Tracking Number: 47828

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life

Project Name/Number: CML-2/61.7/61.7

Columbian Life Insurance Company \$100.00 01/28/2011 44170262

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

### **Correspondence Summary**

### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	01/31/2011	01/31/2011

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

### **Disposition**

Disposition Date: 01/31/2011

Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

Schedule	Schedule Item	Schedule Item Status Public Access
Supporting Document	Flesch Certification	Yes
Supporting Document	Application	Yes
Supporting Document	Life & Annuity - Acturial Memo	No
Supporting Document	Authorization	Yes
Supporting Document	Mark-up of changes	Yes
Form	Application for Individual Term Life	Yes
	Insurance	
Form	Application for Reinstatement	Yes

Company Tracking Number: 5431.7

TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life
Project Name/Number: CML-2/61.7/61.7

### Form Schedule

Lead Form Number: FORM NO. A432-CL

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM NO. A432-CL	• •	Application for Individual Term Life Insurance	Revised	Replaced Form #: FORM NO. A430-Cl Previous Filing #: FRCS- 126924641/DOI# 47481	50.000	FORM NO. A432-CL- John Doed Distilled.pdf
	FORM NO. A433-CL		Application for Reinstatement	Revised	Replaced Form #: FORM NO. A431-Cl Previous Filing #: FRCS- 126924641/DOI# 47481	50.000	FORM NO. A433-CL- John Doed Distilled.pdf

### **COLUMBIAN LIFE INSURANCE COMPANY**

APPLICATION FOR INDIVIDUAL **TERM LIFE INSURANCE POLICY** 

HOME OFFICE: CHICAGO, IL ADMINISTRATIVE SERVICE OFFICE: [4704 VESTAL PARKWAY EAST

		. 100 - 101 101	A C C 11 IC 1 1 II (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1	L, (C)
PO Box 1381, Bingh	namton, NY 1	3902-1381		

(800) 423-9765 / www.cfglife.com)	2-1301					MAIL PO	OLICY TO	): 🗌 Agen	t pd′o∖	vner	
1. PROPOSED INSURED											
Name (Last, Middle Initial, First)  **DE M John			curity Nun		Age 35	Date	of Birth	15	State of	f Birth	
Home Address/Ant. No. City State 7		ity	Mo	64105		*	Phone Nu	mber: DA H			Cell
<ol><li>OWNER (Complete only if Owner in the complete only in the com</li></ol>			ured.)								
Name of Owner				Social Security	/ Numbe	er	Relation	iship to Prop	osed Ins	ured	
Mailing Address/ (If different from Insu	ired)										
3. BENEFICIARY											
Primary Beneficiary Designation: (Ful		•	nsured)	Contingent Be	-	/ Design	ation: (Fu	ll Name & R	elationsh	ip to Insure	ed)
JANE M DOE,  4. POLICY INFORMATION	>fa	5E_		Jov	IN	D <i>oe</i>	***************************************	Son	<u> </u>		
Please select your preference for rec	eivina correst	ondence from	mus: 🗇 t	IS Mail 57 Fm	ail F	mail Add	iress		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	2	
(If you choose Email please make sur				75 man 45 cm		Joh		onca:	st-n	et	
PLAN OF INSURANCE:  15 Year Term	m □ 30 \	ear Term	RIDERS; [□ Accid □ Waive	ental Death Ben er of Premium – ren's Term Insur	efit Disabili	ty		AMOUNT O INSURANC (Face Amo	OF CE	AMOUNT PAID WIT APPLICA	<sup>-</sup> H
100% Return of Premium Benefit ☐ 20 Year Term ☐ 30 Year			☐ Accel	erated Death Be erated Death Be ility Income Ride nly Benefit	enefit – (		II.	\$ 10,000	>	\$ 0.0	00_
Payment Mode: ဩ Annual ☑ EFT - Please specify Annual, Ser ☑ Draft 1st Premium? (Draft date n		Monthly			e EFT (	options o	n Page 4		sted Effe	ctive Date	
Children's Rider Amount:	Unite (Ch	ildran ara n	atural eto	p, and legally a	dontad	childre	n \ ""				
Name		of Birth		leight / Weight	uopteu		111./	Benefi	ciary		
				/	<del></del>	1		children, incl	uding Ch	ildren add	ed
				1		arter	Issue Dai	æ.			
***************************************				1		NAM	E:				
			***************	1	····	-					
				1		REL/	ATIONSH	IP:			
5. HEALTH HISTORY				<u> </u>		<u> </u>		<del></del>	······································		
SECTION A.						***************************************				YEŞ	NO
<ol> <li>Are all proposed insureds US citizen.</li> <li>Are you currently employed? If "I</li> </ol>										TÍ CÍ	
Occupation: Managen Annual Income: 80,000	) OD	Tota	Househol	d Income:	000	2001	DD				
<ol><li>Have you obtained a home mort</li></ol>	gage or refin	anced an ex	isting mort	gage, been mai	rried and	d/or had	or adopt	ed a child in	the last	: /	
three (3) years? (If "NO," do not of the control of		se provide de	tails.							[ <u>]</u>	
If "YES," Driver's License No. an	d State:	71011	7 -	Mo							_
<ol> <li>In the past three (3) years, has ar</li> <li>Been on probation, parole, t</li> </ol>			ad or or al-	ed autility to say	crime o	r ta nace	aeeinn n	distribution	of druge		
or any other illegal substanc	e?		-			·					
<ul> <li>Been convicted of three or r driver's license suspended or</li> </ul>	r revoked?	violations, be	en convict	ed of driving un	der the	influence	e of alcoh	ol or drugs,	or had a		₽′
If "YES" to above, please provide  Have you used tobacco or any ni	details:	te in the nee	t twolvo /1	2) months (to in	cluda ci	aaraltae	cionre e	nufflchawldi	n pinos		

		5" to questions in Sections B or				YES	NO
1.	or Human Immi	ed insured been diagnosed as ha unodeficiency Virus (HIV) Infectic ilth care provider?	ving Acquired ons (symptom	Immune Deficiency Syndrome (AIDS), A natic or asymptomatic) or been treated	IDS Related Complex (AR for AIDS, ARC, or HIV by	y a _	171
2. 3.	Has any propose		recommended	f for an organ or bone marrow transplant	?		À Ą
		or confined to any hospital, nursin-	g home, or oth	her medical facility?			d
	<ul> <li>b. Using any c</li> </ul>	of the following: walker, wheelcha	ir, electric sco	oter, oxygen or catheter?			d D
۱,	If "YES," please		-1-66 15	<del>7</del> 21	<del></del>		
4.	Current Height:	Current We history of weight loss of more that		o lart year?		_	Ø
	If "YES," please	provide details:	ali 10 lb5. III (II	ic last year!			
5.		(3) years has any proposed insur	red:				
				30 feet, parachuting, skydiving, rock or r	nountain climbing, speeds	(in	
		) in excess of 100 mph (land or wa			J. 1	` 🗆	Ø
	b. Flown as a	student pilot, or private pilot with	over 250 fligh	t hours per year, used an ultra-light aircr	aft or plan such activity in t	the _	
SEC	next 12 mor	IIIIS!		<u> </u>		YES	NO NO
1.		(3) years has any proposed insu-	ired heen ded	clined, postponed, rated or denied reinsta	stement or asked to havey		INO
••		insurance company?		simos, podiponou, ratou or demou remati	noment or district to pay ca		Ø
2.		5) years, has any proposed insure	ed:			_	تغر
				nphetamines, marijuana or other drugs	except as prescribed by	y a	_
	physician?						Ø
	b. Been advise abuse?	ed by a healthcare professional	to reduce or	stop alcohol or drug use or received t	reatment for alcohol or di		
3.		sed insured have or has had a	diagnosis of a	diabetes prior to the age of 35 and/or o	synerienced complications	of $\Box$	Ø
υ.	diabetes, includi	na insulin shock, diabetic coma.	Retinopathy (	eye), Nephropathy (kidney), Neuropathy	nerve circulatory) disord	ler	
	leg ulcers, ampu	tation or diabetes not under contro	ol with current	t freatments?	(norto) encodater)/ arcora		
4.				diagnosis of or required follow-up for:			
	a. Cancer (oth	er than basal cell or squamous ce \), transient ischemic attach (TIA),	ell carcinoma d	of the skin), leukemia, or lymphoma?			
	c. Systemic It	nus. sarcoidosis rheumatoid :	, paraiysis : arthritis - Croh	n's Disease or ulcerative colitis, dec	renerative muscle or ner	n/e	محموا
		order, immune system or connecti			1010101010 01 1101		
	<ul> <li>d. Schizophrer</li> </ul>	nia, bipolar disorder, major depi		tal retardation, Down's Syndrome, Alz	heimer's disease, dement	tia,	
		disease or Multiple Sclerosis?		(0100)		. 🗆	
				gery (CABG), coronary angioplasty (PTC			
	angina, nea	lisease or disorder of the brain, or	eripheral arter	omyopathy, congestive heart failure (Chies, blood, liver, pancreas, or kidney (oth	ir), pacemaker, cendinal erthan kidnev stones\?	ioi,	Γ <b>3</b> ′
	f. Emphysema	a, COPD or asthma that has requi	red one or mo	re acute emergency care visits or an inp	atient hospitalization?		Y V V V
digip da. L	g. Epilepsy and	d recurring seizures with the last s	seizure occurr	ing within the past year?		П	Ģ.
5.,	is any proposed	insured awaiting a diagnosis or b	peen advised	to have a surgical operation, a diagnosti	c test or a medical or men		
6.		as not been completed?	d hoon proces	ibed medication or taken any medication	proporihad by a physician		Þ
u.		d or consulted a physician or medi			prescribed by a physician		
TAB		NSWERS IN SECTIONS B OR C					اسسا
	rson Proposed	Medication Name (Copy	Date last	Name & Address of Physician or			
	or Insurance		Date last	I Maille & Muuress of Filysiciali of I	Treatment /	Dates	
		from Pharmacy Label)	taken	Medical Facility	Treatment / Diagnosis	Dates & Duration	
			I		Treatment / Diagnosis	Dates & Duration	
			I				
			I				
<del></del>			I				
			I				
		from Pharmacy Label)	taken	Medical Facility			
		from Pharmacy Label)  APPLYING FOR THE DISABILIT	taken	Medical Facility			
6. A 1.	Are you currently	from Pharmacy Label)  APPLYING FOR THE DISABILIT covered by Workers Compensati	taken  Y INCOME R	Medical Facility	Diagnosis	& Duratio	ons
1.	Are you currently (If yes, you are or	from Pharmacy Label)  APPLYING FOR THE DISABILIT covered by Workers Compensationly eligible to apply for an Off-the-	taken  Y INCOME R	Medical Facility	Diagnosis	& Duration	NO NO
	Are you currently (If yes, you are of Occupation Information Info	from Pharmacy Label)  APPLYING FOR THE DISABILIT covered by Workers Compensationly eligible to apply for an Off-themation:	taken  Y INCOME R	Medical Facility	Diagnosis	& Duration	NO NO
1.	Are you currently (If yes, you are or Occupation Information a. Description of	from Pharmacy Label)  APPLYING FOR THE DISABILIT covered by Workers Compensationly eligible to apply for an Off-themation:	taken  Y INCOME R  on?  Job Disability	Medical Facility  IDER  Income Rider. If so, skip to question #3.	Diagnosis	& Duration	NO 🗆
1. 2.	Are you currently (If yes, you are or Occupation Information a. Description of b. Have you be c. If self-emplo	APPLYING FOR THE DISABILIT covered by Workers Compensation: por duties geen working full-time (at least 30 byed, % of time working at home?	TY INCOME R on? Job Disability	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?	Diagnosis	& Duration	NO NO
1. 2. 3.	Are you currently (If yes, you are or Occupation Information a. Description of b. Have you be c. If self-emplo What is the monti	APPLYING FOR THE DISABILIT covered by Workers Compensation: por duties geen working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable to apply amount of any individual disable to any	TY INCOME R on? Job Disability nours per wee	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?	Diagnosis )	& Duratio	NO 🗆
1. 2.	Are you currently (If yes, you are of Occupation Information a. Description of b. Have you be c. If self-emplo What is the montion the past ten	APPLYING FOR THE DISABILIT covered by Workers Compensation of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disabit (10) years, have you received ca	TY INCOME R TOO PORT INCOME R	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  e you have in force?  nt for, or been diagnosed by a member of	Diagnosis  )  the medical profession as	& Duratio	NO
1. 2. 3.	Are you currently (If yes, you are or Occupation Information a. Description of b. Have you be c. If self-emplo What is the month in the past ten a. Fibromyalgia	APPLYING FOR THE DISABILIT covered by Workers Compensation of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received cast, Chronic Fatigue Syndrome, Chronic Syndrome, Chronic Syndrome, Chronic Syndrome, Chronic Syndrome, Chronic Syndrome, Chro	TY INCOME R TOO PORT OF THE PO	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  E you have in force?  It for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam	Diagnosis  the medical profession as matory arthritis?	YES   having:	NO
1. 2. 3.	Are you currently (If yes, you are or Occupation Information a. Description or b. Have you be c. If self-emplo What is the montion in the past ten a. Fibromyalgia b. Inflammatory c. Disease or in	APPLYING FOR THE DISABILIT covered by Workers Compensatinally eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received casa, Chronic Fatigue Syndrome, Chry Bowel Disease including Crohn's mpairment of the spinal column, n	TY INCOME R ion? Job Disability nours per wee polity insurance are or treatmer onic Epstein-ts Disease or t eck or back, in	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  you have in force?  t for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam Ulcerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back	Diagnosis  the medical profession as matory arthritis? ective Tissue Disorder? strain: herniated disc	& Duratio	NO 🗆
1. 2. 3.	Are you currently (If yes, you are or Occupation Information a. Description or b. Have you be c. If self-emplo What is the montion in the past ten a. Fibromyalgia b. Inflammatory c. Disease or in syndrome, si	APPLYING FOR THE DISABILIT covered by Workers Compensatingly eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received ca a, Chronic Fatigue Syndrome, Chry Bowel Disease including Crohn's mpairment of the spinal column, nurgery of the spine or back, acute	TY INCOME R fon? Job Disability  nours per wee polity insurance are or treatmer onic Epstein- s Disease or U eck or back, in and chronic s	Medical Facility  IDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  you have in force?  at for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam Dicerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back sciatica, or congenital disorders of the spi	Diagnosis  the medical profession as matory arthritis? ective Tissue Disorder? strain: herniated disc	YES   having:	NO 🗆
1. 2. 3.	Are you currently (If yes, you are of Occupation Information a. Description of b. Have you be c. If self-emplo What is the montion in the past ten a. Fibromyalgia b. Inflammatory c. Disease or in syndrome, s d. Recurring dis	APPLYING FOR THE DISABILIT Covered by Workers Compensationly eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received case, Chronic Fatigue Syndrome, Chroy Bowel Disease including Crohn's mpairment of the spinal column, nurgery of the spine or back, acute sease or impairment of other bones	TY INCOME R on? Job Disability nours per wee polity insurance are or treatmer onic Epstein-te s Disease or U eck or back, in and chronic s es or joints, e.	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  e you have in force?  at for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam JIcerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back sciatica, or congenital disorders of the sping, wrist, knee, or shoulder?	the medical profession as matory arthritis? ective Tissue Disorder? strain; herniated disc nal column and back?	YES	NO
1. 2. 3.	Are you currently (If yes, you are of Occupation Information a. Description of b. Have you be c. If self-emplo What is the month In the past ten a. Fibromyalgia b. Inflammatory c. Disease or in syndrome, so d. Recurring dis e. Any emotion	APPLYING FOR THE DISABILIT Covered by Workers Compensationly eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received case, Chronic Fatigue Syndrome, Chroy Bowel Disease including Crohn's mpairment of the spinal column, nurgery of the spine or back, acute sease or impairment of other bones	TY INCOME R on? Job Disability nours per wee polity insurance are or treatmer onic Epstein-te s Disease or U eck or back, in and chronic s es or joints, e.	Medical Facility  IDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  you have in force?  at for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam Dicerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back sciatica, or congenital disorders of the spi	the medical profession as matory arthritis? ective Tissue Disorder? strain; herniated disc nal column and back?	YES   shaving:	NO
1. 2. 3.	Are you currently (If yes, you are of Occupation Information a. Description of b. Have you be c. If self-emplo What is the montion In the past ten a. Fibromyalgia b. Inflammatory c. Disease or in syndrome, s d. Recurring die e. Any emotion Epilepsy)?	APPLYING FOR THE DISABILIT covered by Workers Compensationly eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received cander, Chronic Fatigue Syndrome, Chrony Bowel Disease including Crohn's mpairment of the spinal column, nurgery of the spine or back, acute sease or impairment of other bone all or psychological disorder, included	TY INCOME R on? Job Disability nours per wee polity insurance are or treatmer ronic Epstein- s Disease or U eck or back, in and chronic s es or joints, e. ding stress, an	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  e you have in force?  at for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam JIcerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back sciatica, or congenital disorders of the sping, wrist, knee, or shoulder?	the medical profession as matory arthritis? ective Tissue Disorder? strain; herniated disc nal column and back?	YES	NO 🗆
1. 2. 3. 4.	Are you currently (If yes, you are of Occupation Information a. Description of b. Have you be c. If self-emplo What is the montion In the past ten a. Fibromyalgia b. Inflammatory c. Disease or in syndrome, s d. Recurring die e. Any emotion Epilepsy)?	APPLYING FOR THE DISABILIT covered by Workers Compensationly eligible to apply for an Off-themation: of duties een working full-time (at least 30 hyed, % of time working at home? hly amount of any individual disable (10) years, have you received case, Chronic Fatigue Syndrome, Chroy Bowel Disease including Crohn's mpairment of the spinal column, nurgery of the spine or back, acute sease or impairment of other bone all or psychological disorder, inclusion years, have you filed for or received.	TY INCOME R on? Job Disability nours per wee polity insurance are or treatmer ronic Epstein- s Disease or U eck or back, in and chronic s es or joints, e. ding stress, an	Medical Facility  LIDER  Income Rider. If so, skip to question #3.  k) for the last 12 months?  e you have in force?  at for, or been diagnosed by a member of Barr, Rheumatoid Arthritis or other inflam Ilcerative Colitis, Diabetes, Skin or Connecluding acute and Chronic neck or back sciatica, or congenital disorders of the spig. wrist, knee, or shoulder?  nxiety, depression or nervous system dis	the medical profession as matory arthritis? ective Tissue Disorder? strain; herniated disc nal column and back?	YES   shaving:	NO

7. REPLACEMENT:	YES	ΜÔ
Do you have any existing life insurance or annuities?		Ą
Is this application for insurance intended to replace any life insurance or annuities now in force?		萸
(If "YES," submit any special forms required by the state in which the application is signed.)		l
8. SPECIAL REQUESTS / REMARKS:		
9. CONDITIONS RELATING TO THE APPLICATION:		
I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of	mv kno	wledge
and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the auth		
complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's	other r	ights or
requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as	this appl	lication)
unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the	ie applic	ant (as
permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition	of healt	л of the
Proposed Insured as stated in the application.		
10. AUTHORIZATION & ACKNOWLEDGMENT:	*If1 f	
I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related factorized by the Medical Information Process of the process of		
company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for und		
claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical his		OI .
information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge		agency
employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third		
no longer be protected by federal privacy laws. I understand a telephone interview may be necessary to verify or supplement information		
Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by	a traine	d
interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two		
the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contact		
Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to you	revocat	ion. I
have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment: I acknowledge receipt	and texte	e low
the Information Practices Relating to Underwriting Your Application. I have read and acknowledge the applicable fraud notice require	a by Sta	te law.
[I wish to receive my policy electronically: \( \tilde{\Delta} \) Yes \( \Delta \) No		
(I understand I would receive a link via email to a secure location for my policy packet.)]		
Date of Application x John Doe 11-16-(0) Signature of Proposed Insured (Date)		
Date of Application Signature of Proposed Insured (Date)		
U.S. India of A. I		
Dated At (City, State)  X Signature of Owner (If other than Insured) (I		. 1
Dated At (City, State) Signature of Owner (If other than Insured) (I	Date)	
11. REPORT OF LICENSED AGENT:		
Does the applicant have any existing life insurance or annuities?	S	ON E
Is this insurance intended to replace, in whole or part, any life insurance or annuities?	5 L	_ NO [
I hereby affirm that I personally solicited, witnessed, and completed this application and all answers given above are true and co	rract to	the
best of my knowledge.	1 / / /	, ,
Name of Licensed Agent (Print)  x  Signature of Licensed Agent (required)	<u>//</u> -/(	0-10
best of my knowledge.  The hand Smith  Name of Licensed Agent (Print)  X Signature of Licensed Agent (required)	(Date)	
122	•	
Agent Number % Second Agent Number % (If Splitting) Agent's State License ID No. (in jurisdictions where re	anicad)	
Agent Number % Second Agent Number % (If Splitting) Agent's State License ID No. (in jurisdictions where re	գտո <b>ես)</b>	

FORM NO. A432-CL

MISCELLANEOUS	Complete, If Applicable – Not Required In All States
SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE (The Applicant/Owner may designate a Secondary Addressee/Third Party to	☑ Not Electing A Secondary Addressee/Third Party At this Time. oreceive a copy of Important Notices.)
Name & Address:	
Secondary Addressee / Third Party Authorization I hereby give permission to accept any Important Notices on behalf of the na	amed Proposed Insured.
X	
REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete	oto in fully DO NOT USE FOR DRAFT 1st DREMIUM
	SENTINIA DO NOT COLT ON DIVALLE LA LIMIONI
Amount Paid With Application: \$O, OO ONE TIME ELECTRONIC FUND TRANSFER	
Company ("the Company"). By signing this form, you authorize the Company	•
	gent submits this authorization. The below hereby authorizes the Company to ife insurance.
This will be a one time withdrawal from my account in the amount of \$	
	me of Bank Account Holder: <u>Tohn</u> Doe
Account Type : ☐ Checking or ☐ Savings	
Routing Number: 1123456 Must hav	e 9 digits in routing no.
Account Number: 2 2 2 3 3 5 6 7 8 1 0	Can have up to 17 positions in account no.
11-16-10 X Date Auth	orized Signature as it appears on Bank Records (one time withdrawal)
IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECT BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE A	
☐ FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFEI	
I authorize the payment of debits drawn on my account payable to Columbia agree that if any such debit be dishonored, you shall be under no liability in the control of the	an Life Insurance Company, provided there are sufficient funds in the account. I the event the dishonored debit results in forfeiture of insurance.
	as this Electronic Funds Transfer plan is in effect. No premium shall be deemed nis plan shall in no way change the provisions of the policy with respect to the
	by thirty days written notice to the other party. The Company may terminate the Upon termination of the Electronic Funds Transfer plan, premiums due under the minimum modal premium available at the time of issue.
Bank Name Check	ing (Attach voided check if available.) or ☐ Savings
Transit / Routing No.	Must have 9 digits in routing no.
Account No.	Can have up to 17 positions in account no.
[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th)	(OR) Week (1st – 4th) /Day (Mon – Fri)
beginning in the month of] X	
	uthorized Signature as it appears on Bank Records (ongoing withdrawals)
[Please charge \$ to the following card:  UNSA®  MasterC	Card <sup>®</sup> □ American Express <sup>®</sup> □ Discover <sup>®</sup> □ Debit Card Expiration Date
Card Number Secur	ity Code (on back of card, 3 digits)  (M/M) - (Y/Y)
Date Cardholder Name	X Cardholder Signature]
FORM NO. A432-CL	PAGE 4

### INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

#### INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

#### **IDENTIFICATION**

To obtain the data described above, the insurer may give my name, address and date and place of birth to the above persons or organizations.

#### ACCESS TO INFORMATION

You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

#### WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381, Binghamton, NY 13902-1381].

### MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

CONDIT	IONAL	RECEIPT
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Complete Only When Full Modal Premium Is Received With Application

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from (Print)	, the sum of		on the life of
(Proposed Insured)	Columbian Life Insur	rance Company ("the	Company") accepts this
payment in connection with your application for insurance and, subject to the		is Conditional Receipt	and subject to all the terms
and conditions of the policy applied for, agrees to provide coverage under the	following conditions:		

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

- (1) You had paid the full first modal premium on the policy applied for; and
- (2) All Proposed Insureds were insurable at standard rates on the date of the application; and
- (3) The Company is able to issue the policy as applied for; and
- (4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of \$500,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

e date of the application.

X

Date

X

Signature of Licensed Agent

IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT

UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.

FORM NO. A432-CL-NOTICE

LEAVE WITH PROPOSED INSURED/OWNER

### FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in <u>ARKANSAS</u>, <u>LOUISIANA</u>, <u>RHODE ISLAND and WEST VIRGINIA</u> states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in <u>COLORADO</u> states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in <u>DISTRICT OF COLUMBIA</u> states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in <u>MARYLAND</u> states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in <u>NEW JERSEY</u> states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in <u>NEW MEXICO</u> states: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The law in <u>OHIO</u> states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in <u>PENNSYLVANIA</u> states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in <u>TENNESSEE</u>, <u>VIRGINIA</u> and <u>WASHINGTON</u> states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

## APPLICATION FOR

### COLUMBIAN LIFE INSURANCE COMPANY

REINSTATEMENT HOME OFFICE: CHICAGO, IL ADMINISTRATIVE SERVICE OFFICE: [P.O. Box 1381, Binghamton, NY 13902-1381] NAME OF INSURED POLICY AMOUNT FOR THE OUTSTANDING PREMIUMS: NUMBER RECEIVED FROM THROUGH John 200,00 -10-10 10-10-10 CURRENT ADDRESS: ST CREET/RD: APT# street ZIP CODE: l541 [Please select your preference for receiving correspondence from us: D US Mail Email Address □ Email John @ Comcast (If you choose Email please make sure you supply your email address.)] I hereby apply for reinstatement of the above numbered policy, subject to its provisions and terms. This application is made on the basis of, and is subject to, the following answers: HEALTH HISTORY SECTION A. NO Are you currently employed? If "NO," please explain. manager 2. In the past three (3) years, has any proposed insured: Been on probation, parole, been arrested for, convicted or, or pled quilty to any crime or to possession or distribution of 囟 drugs or any other illegal substance? Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked? ÌΧ If "YES" to above, please provide details: Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)? ΝO SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below. Has any proposed insured been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? N N Has any proposed insured ever received or been recommended for an organ or bone marrow transplant? Is any proposed insured currently: a. Bedridden or confined to any hospital, nursing home, or other medical facility? N N b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? If "YES," please proyide details: Current Height: Current Weight: Any unexplained history of weight loss of more than 10 lbs. in the last year?  $\Box$ Ž If "YES," please provide details: In the past three (3) years has any proposed insured: a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? X b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? YES 岛 In the past three (3) years, has any proposed insured been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? Ď In the past five (5) years, has any proposed insured: a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician?  $\nabla$ b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse? X Does any proposed insured have or has had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments? 囟 In the past ten (10) years, has any proposed insured received a diagnosis of or required follow-up for: a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma? 员 b. Stroke (CVA), transient ischemic attach (TIA), paralysis? Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder? d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, 凶 Parkinson's disease or Multiple Sclerosis? e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney **区区** stones)?  $\Box$ Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization? g. Epilepsy and recurring seizures with the last seizure occurring within the past year? Is any proposed insured awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental Z evaluation that has not been completed? In the past five (5) years, has any proposed been prescribed medication or taken any medication prescribed by a physician or been

hospitalized or consulted a physician or medical facility for any reason?

TABLE FOR "VEC" AL	NOWEDS IN SECTIONS D C					·
	NSWERS IN SECTIONS B or C	1 Deta lest	Name 9 Address of Dhysisian or	Treet-nort !	Doto	
Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Date: & Durati	
101 IIISurance	Itom Pharmacy Laber	taken	Wedical Facility	Diagnosis	& Durau	10115
	-			***************************************		
					···	
			]			
ANSWER ONLY IF AP	PLYING FOR REINSTATEMENT	OF THE DIS	ABILITY INCOME RIDER		YES	NO
1. Are you currently	covered by Workers Compensation	on?			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
		lob Disability I	Income Rider. If so, skip to question #3.)		<i>x</i> >	ļ
<ol><li>Occupation Inform</li></ol>						
a. Description of	duties					_
h Hava yay ha	en working full-time (at least 30 ho		A for the lent 12 months?	<del></del>		
	en working full-tille (at least 50 fit ed, % of time working at home?	mis her weer	.) TOT THE IDSET 2 MOTHERS (			ļ
3. What is the month	ly amount of any individual disabil	lity insurance	you have in force? 1800, 00	9		
4. In the past ten (1	0) years, have you received care	or treatment	for, or been diagnosed by a member of th		having:	
a. Fibromyalgia,	, Chronic Fatigue Syndrome, Chro	onic Epstein-Ba	larr, Rheumatoid Arthritis or other inflamm	natory arthritis?		Ø
			Icerative Colitis, Diabetes, Skin or Connec			区
			cluding acute and Chronic neck or back s			<u> </u>
			ciatica, or congenital disorders of the spin	al column and back?		
	ease or impairment of other bones		j. wrist, knee, or snoulder? Ixiety, depression or nervous system disor	rder lineluding Grand ma		ĽΆ
e. Any emotiona Epilepsy)?	Tot psychological disorder, mode	ing suces, an	xiety, depression or hervous system disor	.081 (IIIOIDDING Orano mai		<b>চ</b> ব
	vears, have you filed for or receiv	ved Disability.	Worker's Compensation or State Disabilit	tv benefits?		प्रक्र वृष् क्ष
If yes, please prov		,,		.,		<b>/</b> *
REMARKS:						
				•		

Page 2

FORM NO. A433-CL

### CONDITIONS RELATING TO THE APPLICATION FOR REINSTATEMENT:

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement of the above policy number can not be approved, any premium remitted with this application will be refunded. I have read the answers and statements in this application and agree:

- (1) they are complete and correctly recorded to the best of my knowledge and belief and
- (2) they shall be the basis upon which the reinstatement will be considered.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

### **AUTHORIZATION AND ACKNOWLEDGMENT:**

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgement. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application.

given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to you revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipend review of the Information Practices Relating to Underwriting Your Application.
understand that a telephone interview may be necessary to verify or supplement information given to the Company on this application for einstatement. This interview may be made from the Administrative Service Office or from a consumer reporting agency by a traine nterviewer acting on the Company's behalf.  Please contact me between the hours of and
RECEIPT OF NOTICES
have read and understand the Conditions Relating to the Application for Reinstatement and the Authorization & Acknowledgment.  acknowledge receipt of the Information Practices Relating to Underwriting Your Application for Reinstatement.  have read and acknowledge the applicable fraud notice required by state law.
11-16-10 x gohn Doe 11-16-10
$\frac{1 - 16 - 10}{\text{Date of Application}} \times \frac{\text{X}  \text{Doe}}{\text{Signature of Insured}} \qquad \frac{11 - 16 - 10}{\text{Oate}}$
Dated At (City & State) / Signature of Owner (If other than Insured) (Date)
1212 x John Smith 156
Agent's State License Identification Number Sighature of Licensed Agent Agent Number (In jurisdictions where required)
REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full)
Bank Name
Fransit / Routing # 123456789 Must have 9 digits in routing #
Account # 15 68 12 7 4 3 1 2 2 5 1 1 2 3 Can have up to 17 positions in account #
authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.
Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be leemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with espect to the termination of such policy upon nonpayment of the premium due.
This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.  I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) / 5 (OR) Week (1st - 4th)/Day (Mon - Fri)
peginning in the month of ]
Date Authorized Signature as it appears on Bank Records

FORM NO. A433-CL

### COLUMBIAN LIFE INSURANCE COMPANY

### NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT.

All premium checks must be made payable to Columbian Life Insurance Company.

Do not make checks payable to the agent or leave the payee blank.

Received from	the sum of \$	to be retained by the	Company while the Reinstatement
Application bearing the above nur	mber is processed. This is not a conditional	eceipt and shall have no binding e	ffect on the Company. The Company
will refund any money remitted h number:	nerewith for a policy that is not approved f	or reinstatement. The Reinstatem	nent Application applies to the policy
effective unless all payments red	reinstatement shall not be effective unless quired for reinstatement have been paid w ffect reinstatement. If reinstatement cannot b	ith the application. The tempora	ry retention of the amount tendered
	, the provisions contained in the policy w ct to the statements and answers contained		all run anew from the date of such
Date	Agent's Signature	Agent N	Number

### INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

This Notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

### INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

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To obtain the data described above, the insurer may give your name, address and date and place of birth to the above persons or organizations.

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You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

### WHERE TO WRITE US

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If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

FORM NO. A433-CL - NOTICE LEAVE WITH INSURED/OWNER

### FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in <u>COLORADO</u> states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in <u>FLORIDA</u> states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in <u>MARYLAND</u> states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in <u>NEW MEXICO</u> states: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The law in <u>OHIO</u> states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in <u>OKLAHOMA</u> states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in <u>PENNSYLVANIA</u> states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in <u>TENNESSEE</u>, <u>VIRGINIA</u> and <u>WASHINGTON</u> states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

SERFF Tracking Number: FRCS-126995957 State: Arkansas State Tracking Number: 47828

Filing Company: Columbian Life Insurance Company

Company Tracking Number: 5431.7

TOI: L04I Individual Life - Term Sub-TOI: L041.500 Other

Product Name: Mortgage Term Life CML-2/61.7/61.7 Project Name/Number:

### **Supporting Document Schedules**

**Item Status: Status** 

Date:

Flesch Certification Satisfied - Item:

Comments: Attachments:

AR RDB APP FILING.pdf AR COC App filing.pdf

> **Item Status: Status**

> > Date:

Application Satisfied - Item:

**Comments:** 

Please see the form schedule for the application.

**Item Status: Status** 

Date:

Authorization Satisfied - Item:

Comments: Attachment:

AUTH 2011 OCR DISTILLED.pdf

**Item Status: Status** 

Date:

Mark-up of changes Satisfied - Item:

**Comments: Attachments:** 

FORM NO. A432-CL \_redlined\_DISTILLED.pdf FORM NO. A433-CL \_redlined\_ DISTILLED.pdf

# STATE OF ARKANSAS READABILITY CERTIFICATION

**COMPANY NAME:** Columbian Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
FORM NO. A432-CL	*
FORM NO. A433-CL	*

<sup>\*</sup> Scores a 50+ when combined with the policy.

Dorothy M. Mie, FLMI, AIRC

Assistant Vice President, Policy Filing and Assistant Secretary

January 27, 2011

Date

## STATE OF ARKANSAS CERTIFICATION OF COMPLIANCE

**Company Name:** Columbian Life Insurance Company

Form Titles: Application for Individual Term Life Insurance, Application for

Reinstatement

Form Numbers: FORM NO. A432-CL, FORM NO. A433-CL

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Dorothy M. Klie, FLMI, AIRC

Assistant Vice President, Policy Filing and Assistant Secretary

January 27, 2011

Date



January 7, 2011

To: The Insurance Commissioner

### Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

**Columbian Life Insurance Company** 

Wordly M. Klie

By:

Title: Assistant Vice President, Policy Filing and Assistant Secretary

### COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL

PO Box 1381, Binghamton, NY 13902-1381 (800) 423-9765 / www.cfglife.com]

ADMINISTRATIVE SERVICE OFFICE: [4704 VESTAL PARKWAY EAST

### APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

MAIL POLICY TO: ☐ Agent ☐ Owner

1. PROPOSED INSURED Name (Last, Middle Initial, First) Social Security Number Sex Date of Birth State of Birth Age Home Address/Apt. No., City, State, Zip Code Phone Number: ☐ Home ☐ Work ☐ Cell 2. OWNER (Complete only if Owner is other than Proposed Insured.) Name of Owner Social Security Number Relationship to Proposed Insured Mailing Address/ (If different from Insured) 3. BENEFICIARY Primary Beneficiary Designation: (Full Name & Relationship to Insured) Contingent Beneficiary Designation: (Full Name & Relationship to Insured) 4. POLICY INFORMATION [Please select your preference for receiving correspondence from us: ☐ US Mail ☐ Email **Email Address** (If you choose Email please make sure you supply your email address.)] PLAN OF INSURANCE: RIDERS: AMOUNT OF **AMOUNT**  □ Accidental Death Benefit **INSURANCE** PAID WITH ☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term (Face Amount): APPLICATION: ☐ Waiver of Premium – Disability 50% Return of Premium Benefit ☐ Children's Term Insurance Rider ☐ 20 Year Term ☐ 30 Year Term ☐ Accelerated Death Benefit – Terminal Illness ☐ Accelerated Death Benefit – Critical Illness 100% Return of Premium Benefit ☐ 20 Year Term ☐ 30 Year □ Disability Income Rider Monthly Benefit ☐ Semi-Annual Requested Effective Date: Payment Mode: ☐ Annual ☐ EFT - Please specify Annual, Semi-Annual or Monthly ☐ Draft 1st Premium? (Draft date must be within 30 days of application date. Please see EFT options on Page 4.) Children's Rider Amount: Units (Children are natural, step, and legally adopted children.) Name Sex Date of Birth Height / Weight Beneficiary Applies to all Children, including Children added after Issue Date. NAME: **RELATIONSHIP:** 5. HEALTH HISTORY SECTION A. YES NO Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa? П Are you currently employed? If "NO," please explain \_ П Occupation: Total Household Income: Annual Income: Have you applied forobtained a home mortgage or refinanced an existing mortgage, been married and/or had or adopted a child in the last three (3) years? (If "NO," do not continue.) Do you have a Driver's License? If "NO," please provide details: If "YES," Driver's License No. and State: \_\_\_\_\_ In the past three (3) years, have youhas any proposed insured: Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance? Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked? If "YES" to above, please provide details: Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)? 

	HUND. II YES	" to questions in Sections B or	C, please pro	DVIGE GELAIIS III CHALL DEIOW.		Y	ES	NO
1.	Have you Has ar	ny proposed insured been diagn	nosed as hav	ring Acquired Immune Deficiency Sync				
ſ	Complex (ARC),	or Human Immunodeficiency Viru	us (HIV) Infec	tions (symptomatic or asymptomatic) or	been treated for AIDS, Al	RC,		
		cian or health care provider?				[		
2.			or been recor	mmended for an organ or bone marrow t	ransplant?	[		
3.	Are youls any pro	posed insured currently:						
	<ul> <li>a. Bedridden o</li> </ul>	r confined to any hospital, nursing	g home, or oth	ner medical facility?				
		the following: walker, wheelchai	r, electric sco	oter, oxygen or catheter?		[		
	If "YES," please p	orovide details:						
4.	Current Height: _	Current We	eight:	<del></del>				_
	Any unexplained	history of weight loss or of more t	than 10 lbs. in	the last year?				
_	If "YES," please p	provide details:			<del></del>			
5.	In the past three	(3) years <del>have you</del> has any propos	<u>sed insured:</u>	30 feet, parachuting, skydiving, rock or r		<i>(</i> :		
	a. Engaged in:	hang-gliding, cliff diving, scuba	diving over 13	30 feet, parachuting, skydiving, rock or r	nountain climbing, speeds		_	_
		in excess of 100 mph (land or wa						
			over 250 flight	t hours per year, used an ultra-light aircr	aft or plan such activity in	_	_	_
CEO	next 12 mon	ins?		and the state the transfer and the form				NO
		" to questions 1-6 in this section					ES	NO
1.				<u>ed</u> <del>ever</del> been declined, postponed, rate	d or denied reinstatemen			_
		a premium by any insurance com				[		
2.	In the past five (5	) years, <del>have you<u>has any propos</u>e</del>	<u>ed insured</u> :					
	a. Used cocair	ne, narcotics, hallucinogens, bar	biturates, am	nphetamines, marijuana or other drugs	except as prescribed b	y a		
	physician?							
		ed by a healthcare professional t	to reduce or	stop alcohol or drug use or received t	reatment for alcohol or d			
	abuse?					[		
3.	Do you Does any	proposed insured have or has ha	ad a diagnosis	s of diabetes prior to the age of 35 and/	or experienced complicati	ons		
	of diabetes, incl	uding insulin shock, diabetic co	oma, Retinop	athy (eye), Nephropathy (kidney), Ne	uropathy (nerve, circulate			
		rs, amputation or diabetes not un			_	[		
4.	In the past ten (1	0) years, <del>have you</del> has any propos	<u>sed insured</u> re	eceived a diagnosis of or required follow-	up for:			
				of the skin), leukemia, or lymphoma?				
	b. Stroke (CVA	), transient ischemic attach (TIA),	paralysis?	. 5				
				n's Disease or ulcerative colitis, dec	generative muscle or ne		_	_
		rder, immune system or connective			hadaa ah a			
	a. Schizophren	ia, bipoiar disorder, major depr	ression, ment	tal retardation, Down's Syndrome, Alz	neimer's disease, demer		_	
	Parkinson's	disease or Multiple Sclerosis?		man (CADC) assessment and all adv. (DT)	24) haadaahaan madaaan			
	e. Coronary an	ery disease, neart attack, coronal	ry bypass sur	gery (CABG), coronary angioplasty (PT	JA), neart valve replacem	eni,		
	angina, nea	t amnytiinia, congenital neart ui	isease, cardic	omyopathy, congestive heart failure (Cl	<b>TEL DAGERNAKEL DENDINA</b>			
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7. REPLACEMENT:		YES NO
Do you have any existing life insurance or annuities?		
Is this application for insurance intended to replace any life insurance or annuities now		
(If "YES," submit any special forms required by the state in which the application is sign.  8. SPECIAL REQUESTS / REMARKS:	ieu.)	
6. SPECIAL REQUESTS / REWARKS.		
9. CONDITIONS RELATING TO THE APPLICATION:		
I have read the questions and answers in all parts of this application and agree		
and belief. I agree that this application shall form a part of any policy issued. I u complete answer to any question in the application, pass on insurability, make or a	nderstand and agree that no agent has the authorities any central arrangement of the Company's	ority to waive a
requirements; that any policy applied for shall not take effect (except as provided in the		
unless and until the policy has been issued and delivered and the full first premium,		
permitted by the Company) and stipulated in the policy, has been paid and accepted		
Proposed Insured as stated in the application.		
10. AUTHORIZATION & ACKNOWLEDGMENT:  I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy bene	ofit manager other modical or modically related fac	ility incurance
company, the Medical Information Bureau, consumer reporting agency, or other organize		
me or any proposed insured, to give any such information to Columbian Life Insurance	Company ("the Company") or its reinsurers for under	erwriting or
claims purposes. This authorization also includes information about drugs, alcoholism,		
information. To facilitate rapid submission of such information, I authorize all said sourcemployed by the Company to collect and transmit such information. I understand my in		
no longer be protected by federal privacy laws. I understand a telephone interview ma		
Company on this application. This interview may be made from the Administrative Serv	vice Office or from a consumer-reporting agency by	a trained
interviewer acting on the Company's behalf. A photocopy of this form will be as valid as		
the date shown below, and will survive my death if it occurs during such two (2) year pe		
Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any informa have read and understand the Conditions Relating to the Application and the Authoriz		
the Information Practices Relating to Underwriting Your Application. I have read and a		
[I wish to receive my policy electronically: ☐ Yes ☐ No		
(I understand I would receive a link via email to a secure location for my policy pa	acket.)]	
X		
Date of Application Signature of Proposition	ed Insured <del>(Parent/Guardian if 15 or under)</del> (C	 Date)
Signature of French		4.5)
X	(If other than Insured) (I	
Dated At (City, State) Signature of Owner	(If other than Insured) (I	Date)
11. REPORT OF LICENSED AGENT:		
		S NO
Does the applicant have any existing life insurance or annuities?	YE	S □ NO
(If "YES," submit any special forms required by the state in which the application is signed HAS THE TELEPHONE INTERVIEW BEEN COMPLETED?	i.) 	.c = NO
HAS THE TELEPHONE INTERVIEW BEEN COMPLETED?		S NO
I hereby affirm that I personally solicited, witnessed, and completed this applicati	ion and all answers given above are true and co	rrect to the
best of my knowledge.		
Name of Licenced Agent (Print)	gnature of Licensed Agent (required)	(Data)
Name of Licensed Agent (Print) Sig	gnature of Licenseu Agent ( <i>requirea)</i>	(Date)
Agent Number % Second Agent Number % (If Splitting) Ag	ent's State License ID No. (in jurisdictions where re	:quired)

FORM NO. <del>A430<u>A432</u>-</del>CL PAGE 3

MISCELLANEOUS Complete, If Applicable – Not Required In All	States
SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE  (The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)  Name & Address:	
Secondary Addressee / Third Party Authorization I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.	
v	
Signature of Secondary Addressee/Third Party (If Required)	
REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full) DO NOT USE FOR DRAFT 1st PREMIUM	
Amount Paid With Application: \$  ONE TIME ELECTRONIC FUND TRANSFER	
For Electronic Funds Transfer, your agent will submit your application for insurance and this authorization for payment to Columbian Life Ins Company ("the Company"). By signing this form, you authorize the Company to initiate an electronic funds transfer from your bank account.	
Please note that your bank account may be debited the same day your agent submits this authorization. The below hereby authorizes the Comp draw an electronic fund transfer from my bank account for payment of new life insurance.	any to
This will be a <b>one time withdrawal</b> from my account in the amount of \$ from the account detailed below.	
Financial Institution: Name of Bank Account Holder:	
Account Type :   Checking or  Savings	
Routing Number: Must have 9 digits in routing no.	
Account Number: Can have up to 17 positions in account no	).
Date  Authorized Signature as it appears on Bank Records (one time withdrawa	<u></u>
IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUNDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT INFORMATION IF IT IS DIFFERENT THAN STATED ABOVE.	1
☐ FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER	
I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.	ount. I
Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be do to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to termination of such policy upon nonpayment of the premium due.	
This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may termina EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due u the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.	
Bank Name	
Transit / Routing No. Must have 9 digits in routing no.	
Account No. Can have up to 17 positions in account no.	
[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) (OR) Week (1st - 4th) /Day (Mon - Fri)	
beginning in the month of] X	
Name of Bank Account Holder Date Authorized Signature as it appears on Bank Records (ongoing withdra	ıwals)
[Please charge \$ to the following card: □ VISA® □ MasterCard® □ American Express® □ Discover® □ Debit  Card Expiration Date	
Card Number Security Code (on back of card, 3 digits) (M/M) - (Y/Y)	;
Date Cardholder Name Cardholder Signature]  FORM NO. A430A432-CL	PAGE 4

### INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

### INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

#### IDENTIFICATION

To obtain the data described above, the insurer may give my name, address and date and place of birth to the above persons or organizations.

### **ACCESS TO INFORMATION**

You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

#### WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381, Binghamton, NY 13902-1381].

### MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

### CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application	

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.					
Received from (Print)	, the sum of	on the life of			
(Proposed Insured)		accepts this			
payment in connection with your application for	insurance and, subject to the terms and conditions of this Conditional Receipt and subject to	all the terms			
and conditions of the policy applied for, agrees to	o provide coverage under the following conditions:				

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

- (1) You had paid the full first modal premium on the policy applied for; and
- (2) All Proposed Insureds were insurable at standard rates on the date of the application; and
- (3) The Company is able to issue the policy as applied for; and
- (4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of \$500,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

The date of the approach in	
	Χ
Date	Signature of Licensed Agent

IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.

### FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in <u>ARKANSAS</u>, <u>LOUISIANA</u>, <u>RHODE ISLAND and WEST VIRGINIA</u> states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in <u>COLORADO</u> states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in <u>MARYLAND</u> states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in <u>NEW MEXICO</u> states: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The law in <u>OHIO</u> states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

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### **APPLICATION FOR** REINSTATEMENT

### **COLUMBIAN LIFE INSURANCE COMPANY**

HOME OFFICE: CHICAGO, IL ADMINISTRATIVE SERVICE OFFICE: [P.O. Box 1381, Binghamton, NY 13902-1381]

	NAME OF INSURED					OUTSTANDING PREMIUMS		
		NUMBER	RECEIV \$	ED	FROM		ROUGH	
CL	IRRENT ADDRESS: STREET/RD:		Ψ		APT#			
CIT					PHONE NUMBER:			
[Please select your preference for receiving correspondence from us:  US Mail  Email Address  (If you choose Email please make sure you supply your email address.)]								
I hereby apply for reinstatement of the above numbered policy, subject to its provisions and terms. This application is made on the basis of subject to, the following answers:							of, and is	
HE	ALTH HISTORY							
<b>SE</b> 1.	CTION A.	aaca aynlain					YES	NO
Occupation:							Ц	Ш
2.	In the past three (3) years, have youhas a  Been on probation, parole, been arrow		ilty to any crime	or to po	ssession or distribution	of		
	<ul><li>drugs or any other illegal substance</li><li>Been convicted of three or more mo</li></ul>		driving under th	ne influer	nce of alcohol or drugs.	or had	Ш	Ц
	a driver's license suspended or revo If "YES" to above, please provide details:	okeď?	g					
3.	Have you used tobacco or any nicotine pipes, nicotine patch and nicotine gum)?	e products in the past twelve (12)	months (to inc	clude ciç	garettes, cigars, snuff/c	hew/dip,		
	CTION B. If "YES" to questions in So	Sections B or C, please provide (	details in chart	below.	undrama (AIDC) AIDC	Dolotod	YES	NO
1.	Have you Has any proposed insured bee Complex (ARC), or Human Immunodefici ARC, or HIV by a physician or health care	ciency Virus (HIV) Infections (syn	nptomatic or as	ymptom	atic) or been treated fo	or AIDS,		
2. 3.	Have you Has any proposed insured ever r Are youls any proposed insured currently:	received or been recommended for	r an organ or bo	one mar	row transplant?			
J.	Bedridden or confined to any hospital     Using any of the following: walker, w	I, nursing home, or other medical f	acility?					
4.	If "YES," please provide details:	urrent Weight:					Ц	
4.	Any unexplained history of weight loss or If "YES," please provide details:	of more than 10 lbs. in the last year	ır?					
5.	In the past three (3) years have youhas an a. Engaged in: hang-gliding, cliff diving	ny proposed insured:	achutina skydiv	ing roc	k or mountain climbing	enoode		
	(in any vehicle) in excess of 100 mph b. Flown as a student pilot, or private pilot	g, scuba diving over 130 reet, par i (land or water) or plan such activi	ty in the next 2	years?	ircraft or plan such acti	, speeus		
	the next 12 months?					vity ii i		
SE	CTION C. If "YES" to ques	stions 1-6 in this section, please					YES	NO
1.	In the past three (3) years, have you eve asked to pay extra premium by any insuran	exhas any proposed insured been ince company?	declined, postp	oned, ra	ated or denied reinstate	ement or		
2.	In the past five (5) years, have youhas any a. Used cocaine, narcotics, hallucinogens	<u>y proposed insured</u> :	riiuana or othor	druas a	veent as prescribed by	a		
	physician?	•	,	Ü	, ,			
_	<ul> <li>Been advised by a healthcare profession abuse?</li> </ul>	·	· ·					
3.	Do you Does any proposed insured have complications of diabetes, including insuling	lin shock, diabetic coma, Retinop	athy (eye), Ner	ohropath				
4.	circulatory) disorder, leg ulcers, amputation In the past ten (10) years, have youhas an	on or diabetes not under control wi	h current treatm	nents?		•		
٦.	<ul> <li>a. Cancer (other than basal cell or squam</li> </ul>	nous cell carcinoma of the skin), le			now up for.			
	<ul><li>b. Stroke (CVA), transient ischemic attach</li><li>c. Systemic lupus, sarcoidosis, rheuma</li></ul>	atoid arthritis, Crohn's Disease	or ulcerative	colitis, d	legenerative muscle of	or nerve		
	disease/disorder, immune system or co d. Schizophrenia, bipolar disorder, majo	or depression, mental retardatior	, ı, Down's Sync	drome, A	Alzheimer's disease, d	ementia,		
	Parkinson's disease or Multiple Scleros e. Coronary artery disease, heart atta	sis? ack, coronary bypass surgery	(CABG), coron	ary and	ijoplasty (PTCA), hea	rt valve		
	replacement, angina, heart arrhythmia defibrillator, aneurysm, disease or disc	a, congenital heart disease, cardic	myopathy, cong	gestive h	neart failure (CHF), pac	emaker,		
	stones)?			•		,		
_	<ul> <li>f. Emphysema, COPD or asthma that hage.</li> <li>g. Epilepsy and recurring seizures with the</li> </ul>	ne last seizure occurring within the	past year?					
5.	Are you's any proposed insured awaiting or mental evaluation that has not been cor	mpleted?	· ·		· ·			
6.	In the past five (5) years, have youhas any or been hospitalized or consulted a physicia	proposed been prescribed medical		ny medic	cation prescribed by a p	hysician	П	П

TAE	BLE FOR "YES" AN	NSWERS IN SECTION <mark>S B or</mark> C-C	<b>WESTIONS 1</b>	L <del>-6</del>			
Person Proposed Medication Name (Copy Date last Name & Address of Physician or Treatment /		Dates					
	for Insurance	from Pharmacy Label)	taken	Medical Facility	Diagnosis	& Durat	ions
ANS	SWER ONLY IF AP	PLYING FOR REINSTATEMENT	OF THE DIS	ABILITY INCOME RIDER	1	YE	NO
						S	
1.	Are you currently	covered by Workers Compensation	n?				
				ncome Rider. If so, skip to question #3.)			
2.	Occupation Inform						
	<ul> <li>a. Description of</li> </ul>	duties					
		en working full-time (at least 30 ho	ours per week	) for the last 12 months?			
2	c. If self-employe	ed, % of time working at home?					
3.	what is the month	ly amount of any individual disabil	ity insurance y	you nave in force?	a a madical profession as k	soula a	
4.				or, or been diagnosed by a member of the		<u> </u>	
				arr, Rheumatoid Arthritis or other inflamr cerative Colitis, Diabetes, Skin or Conne			
				cluding acute and Chronic neck or back:		Ш	
				ciatica, or congenital disorders of the spir			
	d Recurring dise	ease or impairment of other bones	or ioints ea	wrist knee or shoulder?	iai column and back:		
				xiety, depression or nervous system disc	order (including Grand mal		
	Epilepsy)?		g,			П	
5.		years, have you filed for or receiv	ed Disability,	Worker's Compensation or State Disabil	ity benefits?		
	If yes, please prov	ide details				_	
REN	MARKS:						

FORM NO. A431A433-CL Page 2

#### CONDITIONS RELATING TO THE APPLICATION FOR REINSTATEMENT:

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement of the above policy number can not be approved, any premium remitted with this application will be refunded. I have read the answers and statements in this application and agree:

- (1) they are complete and correctly recorded to the best of my knowledge and belief and
- (2) they shall be the basis upon which the reinstatement will be considered.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

### AUTHÓRIZATION AND ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application.

I understand that a telephone interview may be necessary to verify or supplement information given to the Company on this application for reinstatement. This interview may be made from the Administrative Service Office or from a consumer reporting agency by a trained interviewer acting on the Company's behalf. Please contact me between the hours of \_\_\_\_\_ and \_\_\_\_\_. RECEIPT OF NOTICES I have read and understand the Conditions Relating to the Application for Reinstatement and the Authorization & Acknowledgment. I acknowledge receipt of the Information Practices Relating to Underwriting Your Application for Reinstatement. I have read and acknowledge the applicable fraud notice required by state law. X \_\_\_\_\_\_\_ Signature of Insured (Parent/Guardian if 15 or under) Date of Application Signature of Owner (If other than Insured) Dated At (City & State) (Date) Signature of Licensed Agent Agent's State License Identification Number Agent Number (In jurisdictions where required) REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full) Bank Name ☐ Checking (Attach voided check if available.) ☐ Savings Transit / Routing # Must have 9 digits in routing # Account # Can have up to 17 positions in account # I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance. Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due. This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue. [I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) (OR) Week (1st - 4th) // Day (Mon - Fri) beginning in the month of \_\_\_\_\_\_.] X \_\_\_\_\_\_\_X Authorized Signature as it appears on Bank Records

FORM NO. A4313-CL Page 3

### COLUMBIAN LIFE INSURANCE COMPANY

### NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

All premium checks must be made payable to Columbian Life Insurance Company.

Do not make checks payable to the agent or leave the payee blank.

Received from	tne sum of \$	to be retaine	a by the Company (	wniie the Reinstatemer
Application bearing the above number is				
will refund any money remitted herewi	th for a policy that is not approved for	or reinstatement. The	Reinstatement Applica	ition applies to the polic
number:	·			
It is understood and agreed that reinst				
effective unless all payments required				
herewith shall not be deemed to effect re	einstatement. If reinstatement cannot b	oe approved, any premi	um remitted with this app	lication will be refunded.
To the outent norm!tted by law the	proviologo contained in the policy w	ubiah ralata ta imaanta	معمد حسي المامان	u fram the date of our
To the extent permitted by law, the preinstatement, but only with respect to the			Stability Shall run anev	v from the date of Suc
remaratement, but only with respect to the	ic statements and answers contained	iii tiiis application.		
Date Agent	t's Signature		Agent Number	
	3		_ 5	

### INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

This Notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

### INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

### IDENTIFICATION

To obtain the data described above, the insurer may give your name, address and date and place of birth to the above persons or organizations.

#### ACCESS TO INFORMATION

You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

### WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381 Binghamton, NY 13902-1381].

#### MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

#### FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

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